EDMUND G. BROWN JR.
Attorney General of California
LINDA K. SCHNEIDER
Supervising Deputy Attorney General
NICOLE R. COOK
Deputy Attorney General
State Bar No. 263607
110 West "A" Street, Suite 1100
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-2143
Facsimile: (619) 645-2061
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: CHRISTOPHER RYAN WANAMAKER 19783 Sea Street Brady, NE 69123 Registered Nurse License No. 681951 Respondent.	Case No. 2010-647 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about June 29, 2006, the Board of Registered Nursing issued Registered Nurse License Number 681951 to Christopher Ryan Wanamaker, RN (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and expired on May 31, 2008, and has not been renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Section 2811(b) of the Code provides, in pertinent part, that the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

7. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
>
> . . . .
>
> (4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California healthy care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.
>
> . . . .

8. Section 2762 of the Code states:

> In addition to other acts constituting unprofessional conduct within the meaning of

this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

. . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

REGULATORY PROVISIONS

9. Title 16, California Code of Regulations, section 1442, provides:

As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

10. Title 16, California Code of Regulations, section 1443, provides:

As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

11. Title 16, California Code of Regulations, section 1443.5, provides:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COST RECOVERY

12. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

13. Dilaudid is a Schedule II controlled substance pursuant to Health and Safety Code section 11055(b)(1)(k) and is a dangerous drug pursuant to Business and Professions Code section 4022. Dilaudid is a brand name for the generic drug hydromorphone and is used to treat pain.

14. Morphine/Morphine Sulfate is a Schedule II controlled substance pursuant to Health and Safety Code section 11055(b)(1)(M) and is a dangerous drug pursuant to Business and Professions Code section 4022. Morphine is in a class of drugs called narcotic analgesics and is used to treat pain.

15. Toradol, a brand name for ketorolac, is a dangerous drug pursuant to Business and Professions Code section 4022. Toradol is an NSAID used to reduce inflammation and pain.

FACTUAL ALLEGATIONS

16. From September 11, 2006 through April 2, 2007, Respondent was employed with MedStaff HealthCare Solutions, Inc., as a registered nurse and was assigned "on contract" to the Emergency Department at Eisenhower Medical Center located in Rancho Mirage, California. During that time period Respondent frequently prepared nurse written orders that were not transcribed with the correct notations per the hospital's policy, despite counseling and coaching.

17. On or about April 1, 2007 between 1900-0100 hours, the nursing team leader of the Emergency Department observed approximately 10 charts on Respondent's desk. At approximately 0500 hours, the team leader asked if she could resume care of Respondent's patients so that Respondent had an opportunity to "catch up" with his charts. Respondent declined and stated that he would stay over his shift to complete the charting. Respondent worked the following evening shift from April 2, 2007 at 1900 hours to April 3, 2007 at 0700. During that shift, the team leader approached Respondent and asked him what time he had finished his charting from the previous evening. Respondent stated that he "took 4 charts home" to complete his charting and then returned them to work on his next shift. Because the team leader was alarmed by Respondent's behavior, she admonished him and told him that he needed to keep up with his charts during the shift and could not take them out of the hospital.

18. At or around 0500 hours, the team leader assisted Respondent in discharging two of his patients. The team leader then noticed that Respondent had not charted anything on either one of the patients' charts. She then logged onto McKesson AcuDose-Rx[1] to check what time Respondent had withdrawn medication for one of the patients. At that point, the team leader found that Respondent had withdrawn Morphine 10 mg IV, Dilaudid 2 mg IV, Phenergan 25 mg IV, and Zofran 4 mg IV, even though these medications were not ordered by the physician.

[1] McKesson AcuDose-RX is a decentralized medication dispensing cabinet that automates the storing, dispensing, and tracking of medications in resident care areas. The system dispenses pharmaceutical medications to an individual authorized to access the system by user-id and password known only to that individual.

Alarmed, the team leader reviewed Respondent's other patient charts and noticed several other discrepancies of a similar nature. She reported this information to her supervisor, C.C., the Clinical Director of Eisenhower.

19. C.C. conducted an audit of the hospital records and AcuDose-Rx reports for patients that had been assigned to Respondent from April 2, 2007 through April 3, 2007 and determined the following:

20. Patient 2242316:

This was a 77 year old patient with chest and epigastric pain. On April 2, 2007 at 1933 hours, Respondent removed from the AcuDose-Rx machine Dilaudid 2 mg for this patient even though there was no physician order for this medication. There is no record that Respondent administered the medication and no record of wastage. Therefore, 2 mg of Dilaudid are unaccounted for.

21. Patient 414599:

This was an 84 year old patient having sustained a fall with a right hip injury. On April 3, 2007, there was a physician order for Dilaudid 1 mg IVP. On April 3, 2007 at 0652 hours, Respondent removed Dilaudid 2 mg. from the AcuDose-Rx Machine. Respondent recorded that he administered 1 mg. of Dilaudid at 0650 hours. There is no record of wastage or documentation of administration for the other 1 mg. of Dilaudid. Therefore 1 mg. of Dilaudid is unaccounted for.

22. Patient 1574374:

This was a 63 year old patient with a right shoulder injury. On April 1, 2007, the patient's physician ordered a single dose of Dilaudid .5 mg to be administered to this patient. On April 1, 2007, Respondent withdrew Dilaudid 2 mg. vials at 2154 hours and 2334 hours, exceeding the prescribed single order of .5 mg. Respondent documented that he administered .5 mg at 2210 hours and 2230 hours. Thus, 3 mg of Dilaudid is unaccounted for and there is no record of wastage or administration.

23. Patient 1640232:

This was a 77 year old patient with left arm pain, shortness of breath and extensive cardiac history. The physician ordered Morphine 2 mg IVP at 0620 hours. A transcribed second order for "Morphine Sulfate 2 mg IVP repeat for CP" with the appearance of Respondent's writing is documented in the patient's record. There is a third order on the admitting physician orders for "Morphine 2mg IV x 1 at 0700." On April 3, 2007, Respondent removed a 10 mg vial of Morphine from the AcuDose-Rx machine for this patient. Respondent documented administration of 2 mg. of Morphine at 2204 hours and another administration of 2 mg. of Morphine at 2335 hours for this patient. There is no record of waste of narcotics or administration for the other 6 mg. of Morphine. Therefore, 6 mg. of the 10 mg vial that Respondent withdrew is unaccounted for.

It is not a standard nursing practice to administer Morphine IV for patients admitted to a hospital with a diagnosis for chest pain. Medication orders for this patient population are typically limited to one-time doses for acute episodes with a notification to the physician for recurring chest pain in case the patient's condition is worsening or they require more acute care or cardiac intervention. The patient was scheduled for a diagnostic heart catheterization the following morning and thus, this type of order would have been atypical. There is no documentation by Respondent that the patient experienced chest pain prior to the Morphine documented as administered at 2204 hours or 2335 hours and no pain reassessment documented after administration, per nursing standard. Further, there is no documentation that Respondent notified the admitting physician of the change in the patient's condition for persistent chest pain, which is the standard of care for nursing practice.

24. Patient 1514118:

This was a 76 year old patient with two separate physician orders for Dilaudid 1 mg to be administered at 2320 hours and at 0245 hours. On April 3, 2007, Respondent removed Dilaudid 2 mg at 0152 hours, 0336 hours and 0531 from AcuDose-Rx. Respondent documented at 0240 hours that he administered 1 mg of Dilaudid; however, because the legibility was poor, the actual time the Dilaudid was administered to the patient is difficult to read. 5 mg Dilaudid was

unaccounted for and not documented in the patient administration record. There is no record of waste. Further, there are incomplete vital signs and no pain reassessments or blood pressure notations about the patient after administration of medications since 0001 hours, which is not within nursing standards.

25. Patient 445478:

This was an 88 year old patient with an altered level of consciousness and a fall from a standing position. On April 2, 2007 at 1830 hours, the patient was noted to have no pain. At 2005 hours, the physician ordered Morphine 1 mg IV every 4 hours as needed for pain. The AcuDose-Rx records indicated that two Morphine 10 mg vials were removed by Respondent at 1955 hours and 2125 hours, totaling 20 mg. of Morphine. There are two entries by Respondent in the nurse's notes that Morphine 4 mg IVP was administered at 1930 hours and 2135 hours, totaling 8 mg. of Morphine. There was no pain reassessment documented reflecting that the patient had developed pain between 1830 hours and 1930 hours and there is no reassessment of pain in the records after the Morphine was administered. There was no record of wastage or administration for the other 12 mg. of Morphine. Therefore 12 mg. of Morphine Sulfate was unaccounted for. Furthermore, the amount of medication documented as being administered by Respondent was four times the dose ordered by the physician. Two Morphine 4 mg doses for an 88 year old patient with a head injury and altered level of consciousness was excessive.

26. Patient 2494712:

This was a 46 year old patient with abdominal pain and physician orders for Morphine Sulfate 2 mg IVP on April 3, 2007. There is documentation that Morphine 2 mg was administered IVP at 2245 hours in the nursing documentation; however, there is no record of pain reassessment before or after the documented administration of Morphine. There was no documentation of assessments every two hours per Emergency Department nursing standards.

27. Patient 2441825:

This was an 80 year old patient with difficulty breathing/aspiration. Respondent's documentation was inadequate for a patient in acute respiratory distress: there is a lack of complete vital signs including respiratory rate; the neurological assessments are omitted; the

medication summary is incomplete; intake of IV fluids is incomplete; there is a lack of progression of status, care or intervention provided for the patient from 0340 hours to 0630 hours on April 3, 2007 and no reassessment of respiratory status.

28. A review of the Pharmacy Pandora Data Systems[2] reports Anomalous Usage by Station Report for October 1, 2006 through March 20, 2007 identified Respondent as the top user for the following:

a. Morphine 10 mg/ml, 10 mg Injection, far exceeding the mean and the next user frequency;

b. Hydromorphone Injection 2 mg/ml, 2 mg injection, grossly exceeding the mean and the next highest user; and

c. Lorazepam 2 mg/ml, 2 mg injection, twice exceeding the next user and beyond the mean.

29. After reviewing the Pandora Reports, patient charts, and AcuDose-Rx records, Eisenhower Medical Center determined that Respondent had a pattern of narcotic discrepancies. Based upon those discrepancies, Respondent's inadequate nursing documentation and the observations by the nursing leaders of his deteriorating nursing performance, on or about April 3, 2007, Respondent's contract was terminated at Eisenhower Medical Center.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Obtain Controlled Substances Unlawfully)

30. Respondent is subject to disciplinary action for unprofessional conduct under section 2762(a) for obtaining and possessing controlled substances unlawfully as is more particularly set forth in Paragraphs 18 through 25 above and incorporated herein as though set forth in full.

[2] Pandora Data Systems is a computer system that interfaces with Pyxis and AcuDose-Rx. The report can be run for a specific station within the medical center, a specific Registered Nurse user, and by specific drug. The report provides the number of withdrawals of a certain drug by the specific user in a specific area.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct-Falsify or Make Grossly Incorrect or Inconsistent Entries)

31. Respondent is subject to disciplinary action for unprofessional conduct under Code section 2762(e) for falsifying or making grossly incorrect, inconsistent and/or unintelligible entries in the hospital records of Eisenhower Medical Center by withdrawing medication from the AcuDose-Rx system, charging the withdrawal to patients who did not receive the drugs or for whom Respondent did not document administration or wastage of the drug as is more particularly set forth in Paragraphs 16 through 29 above, and incorporated herein as though set forth in full.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Gross Negligence or Incompetence)

32. Respondent is subject to disciplinary action for unprofessional conduct under section 2761(a)(1) of the Code in that during his employment at Eisenhower Medical Center, Respondent was incompetent or grossly negligent in carrying out usual licensed nursing functions as is set forth in Paragraphs 16 through 18 and 23 through 29 above and incorporated herein as though set forth in full.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Disciplinary Action in Nebraska)

33. Respondent is subject to disciplinary action for unprofessional conduct under section 2761(a)(4) of the Code in that his license to practice as a registered nurse in Nebraska was disciplined. The circumstances are as follows:

a. On or about September 13, 2001, the Nebraska Board of Registered Nursing (Nebraska Board) issued Respondent Registered Nurse License Number 59040. On or about May 11, 2006, the Nebraska Board filed a Petition for Disciplinary Actions alleging that Respondent was terminated from his employment for "overmedication with narcotics of patients in the E.D.," administering morphine without a physician's order and poor documentation, among other allegations. On or about May 11, 2006, Respondent signed an Agreed Settlement wherein he consented to the entry of a final disciplinary order which found the allegations of the Petition for Disciplinary action were true and placed "License Limitations" on his registered nursing license.

Among those limitations, Respondent was prohibited from practicing nursing in any state which is a party to the Nurse Licensure Compact, other than Nebraska, without prior written authorization from both the Department and the party state in which Respondent desired to practice. The Order on Agreed Settlement by the Director was filed May 22, 2006.

b. On or about September 24, 2007, the Nebraska Board filed a Petition for Disciplinary Action alleging that Respondent engaged in conduct which constituted habitual intoxication or dependence upon controlled substances and alcohol and constituted grounds for disciplinary action. The Petition asserted the following pertinent factual allegations as a basis for the conduct:

i. Defendant was employed by E.M.C. (Eisenhower Medical Center) through M.S. (MedStaff.)

ii. C.C. (the Clinical Director) of E.M.C. reviewed nine medical records of patients under Defendant's care in April 2007. She observed "there are frequent withdraws of narcotics and benzodiazepine medications including dilaudid, morphine, and ativan beyond standard daily practice. There are consistently medications withdrawn from the McKesson Accudose system without physicians (sic) orders on the medical request." Defendant "has frequent, nurse written orders that are not transcribed with the correct notation per hospital policy ie. V.O.R.B. from Physician." Defendant "has been noted by the ED Charge RN, [C.P.] to have been experiencing significant documentation deficiencies that have not improved despite coaching and have increased over the last three days."

iii. "The nine charts reviewed by E.M.C. showed dilaudid removed for one patient with orders for morphine, six charts showed the amount of narcotics removed for the patient exceeded the amount documented as administered, and all nine charts showed no documentation of excess medication wasted."

iv. "Defendant admitted to Investigator P.P. that he was withdrawing medications at E.M.C., specifically dilaudid and morphine, for personal use.

v. "Defendant's employment with M.S. was terminated in April 2007."

vi. "Testing by The Counseling Center in North Platte, Nebraska, on May 8, 2007 showed Defendant has a diagnostic impression of Polysubstance Dependence, active. Records from The Counseling Center show Defendant has missed two of his six appointments at the Center."

vii. "Defendant was examined by Dr. G.M. on June 4, 2007, and requested refills for Percocet, Lexapro, Flexeril, and Ambien. Defendant was given prescriptions for Lexapro, Flexeril (with a refill), and Ambien."

viii. "From May 7, 2007, through June 6, 2007, Defendant obtained controlled substances through multiple prescriptions from three different physicians at three different pharmacies. Defendant obtained Ambien #150, Oxycodon #180, Flexeril #60, and Lexapro #30."

ix. "On June 12, 2007, Dr. G.M. was contacted by a pharmacist who indicated Defendant was back asking for refills of his medications. The pharmacist indicated two other pharmacists had called indicating Defendant had filled scripts at their pharmacies, too."

c. On October 19, 2007, Respondent entered into an Agreed Settlement (Case No. 80-070338). By signing the Agreed Settlement, Respondent acknowledged that he read the Petition for Disciplinary Action and admitted the allegations for the Petition for Disciplinary Action. The Agreed Settlement was filed November 2, 2007 and Respondent's Nebraska license was revoked effective April 3, 2007.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 681951, issued to Christopher Ryan Wanamaker,

2. Ordering Christopher Ryan Wanamaker to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 6/17/10

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SD2010800266
80458930.doc